

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

CYNTHIA HERNANDEZ
40393 Fabrizio Ct.
Indio, CA 92203

78880 Sanita Drive
La Quinta, CA 92253

Registered Nurse License No. 591197

Respondent

Case No. 2012-178

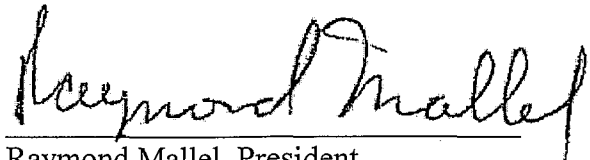
OAH No. 2011120866

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order for Public Reprimand is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **March 8, 2013.**

IT IS SO ORDERED **February 6, 2013.**



Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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Attorneys for Complainant

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9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

12 **CYNTHIA HERNANDEZ**
13 **35751 Gateway Drive, L-1229**
14 **Palm Desert, CA 92211**

15 **AND**

16 **78880 Sanita Drive**
La Quinta, CA 92253

17 **Registered Nurse License No. 591197**

18 Respondent.

Case No. 2012-178

OAH No. 2011120866

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER FOR PUBLIC
REPROVAL**

[Bus. & Prof. Code § 495]

19
20 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Louise R. Bailey, M.Ed., RN (Complainant) is the Executive Officer of the Board of
24 Registered Nursing. She brought this action solely in her official capacity and is represented in
25 this matter by Kamala D. Harris, Attorney General of the State of California, by Erin M. Sunseri,
26 Deputy Attorney General.

27 2. Respondent Cynthia Hernandez (Respondent) is representing herself in this
28 proceeding and has chosen not to exercise her right to be represented by counsel.

1 9. For the purpose of resolving the Accusation without the expense and uncertainty of
2 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
3 basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest
4 those charges.

5 10. Respondent agrees that her Registered Nurse License is subject to discipline and she
6 agrees to be bound by the Board's terms as set forth in the Disciplinary Order below.

7 **CONTINGENCY**

8 11. This stipulation shall be subject to approval by the Board of Registered Nursing.
9 Respondent understands and agrees that counsel for Complainant and the staff of the Board of
10 Registered Nursing may communicate directly with the Board regarding this stipulation and
11 settlement, without notice to or participation by Respondent. By signing the stipulation,
12 Respondent understands and agrees that she may not withdraw her agreement or seek to rescind
13 the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt
14 this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order for
15 Public Reprimand shall be of no force or effect, except for this paragraph, it shall be inadmissible in
16 any legal action between the parties, and the Board shall not be disqualified from further action
17 by having considered this matter.

18 12. The parties understand and agree that facsimile copies of this Stipulated Settlement
19 and Disciplinary Order for Public Reprimand, including facsimile signatures thereto, shall have the
20 same force and effect as the originals.

21 13. This Stipulated Settlement and Disciplinary Order for Public Reprimand is intended by
22 the parties to be an integrated writing representing the complete, final, and exclusive embodiment
23 of their agreement. It supersedes any and all prior or contemporaneous agreements,
24 understandings, discussions, negotiations, and commitments (written or oral). This Stipulated
25 Settlement and Disciplinary Order for Public Reprimand may not be altered, amended, modified,
26 supplemented, or otherwise changed except by a writing executed by an authorized representative
27 of each of the parties.

1 14. In consideration of the foregoing admissions and stipulations, the parties agree that
2 the Board may, without further notice or formal proceeding, issue and enter the following
3 Disciplinary Order:

4 **DISCIPLINARY ORDER**

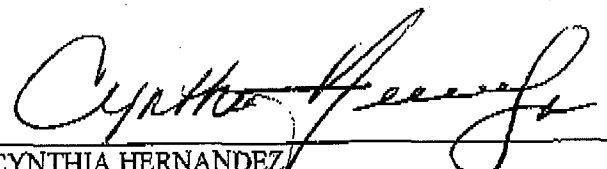
5 IT IS HEREBY ORDERED that Registered Nurse License No. 591197 issued to
6 Respondent Cynthia Hernandez shall, by way of letter from the Board's Executive Officer, be
7 publicly reprovved. The letter shall be in the same form as the letter attached as Exhibit "B" to this
8 stipulation.

9 IT IS FURTHER ORDERED that within 180 days from the effective date of this decision,
10 Respondent shall successfully complete, pass and provide the Board with verifiable proof of
11 passing a course in medication safety administration, approved in advance by the Board or its
12 designee, at her own cost. If Respondent fails to provide verifiable proof of compliance as
13 ordered, Respondent shall not be allowed to renew her Registered Nurse License until.
14 Respondent provides such proof.

15 **ACCEPTANCE**

16 I have carefully read the Stipulated Settlement and Disciplinary Order for Public Repraval.
17 I understand the stipulation and the effect it will have on my Registered Nurse License. I enter
18 into this Stipulated Settlement and Disciplinary Order for Public Repraval voluntarily,
19 knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of
20 Registered Nursing.

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22 DATED: 12-3-12


CYNTHIA HERNANDEZ
Respondent

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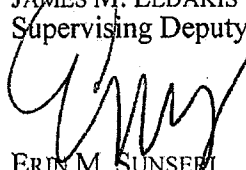
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order for Public Repeval is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: 12-4-12

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General


ERIN M. SUNSERI
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 2012-178

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9 **BEFORE THE**
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No.

2012-178

12 **CYNTHIA HERNANDEZ**
13 **78880 Sanita Drive**
14 **La Quinta, CA 92253**

ACCUSATION

15 **Registered Nurse License No. 591197**

16 **Respondent.**

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22 Consumer Affairs.

23 2. On or about November 14, 2001, the Board of Registered Nursing issued Registered
24 Nurse License Number 591197 to Cynthia Hernandez (Respondent). The Registered Nurse
25 License was in full force and effect at all times relevant to the charges brought herein and will
26 expire on May 31, 2013, unless renewed.

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8. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

10. At all times herein mentioned, Respondent was employed as a registered nurse at the California Institute for Women (CIW), located in Corona, California.

11. On or about November 6, 2007, at approximately 3:10 p.m., Respondent wrote an order from "Dr. M.," for inmate A.T., for "Ristoril 50mg" P.O. B.I.D. (by mouth, twice per day) times 7 days (for treatment of withdrawal from benzodiazepines).

12. Respondent's supervisor (C.G.) checked the 2008 Nursing Drug Book (Drug Book), and discovered that this medication does not exist. C.G. found a medication called "Restoril," which is prescribed for insomnia and not carried on the CIW formulary. C.G. determined that a clarification of the physician's order was necessary.

13. C.G. called Respondent for clarification of the order. Respondent stated that she had spoken with Dr. M., and that he had ordered "Ristoril." C.G. advised Respondent that "Ristoril" does not come in 50mg. Respondent responded "I thought that is what he said."

14. Respondent requested the Drug Book from C.G., and looked up the medication in an effort to determine what the correct order should be. Respondent changed the order in front of C.G., and then denied she had changed the order.

1 15. Respondent modified the incorrect "Ristoril" order by changing the "I" to an "E,"
2 which is not the standard practice of putting a line through the error and rewriting the order. C.G.
3 believed that Respondent was attempting to cover her mistake, rather than clarify the order.

4 16. C.G. asked Respondent about contacting Dr. M., but Respondent said he was not
5 answering. Respondent said she would call "Dr. H." Respondent then advised C.G. that Dr. H.
6 had given an order for Ativan.

7 17. C.G. did not believe the order for Ativan made sense, so she called Dr. H. and gave
8 him all of the patient information, to include the discontinued medication orders. Dr. H.
9 cancelled the Ativan, and gave an order for "Vistaril," which is what C.G. believed may have
10 been the original order. C.G. stated that when you discontinue Trazadone, Vistaril is usually
11 given instead.

12 18. Respondent ordered "Restoril 50mg." Had inmate A.T. been medicated, it could have
13 been a catastrophic error as the maximum dose is 8mg per day. The order was "bounced back"
14 for clarification, as "Restoril" is not a CDCR formulary medication as it may be addictive or
15 cause adverse side effects.

16 19. Respondent did not comprehend the intention of the prescribing physician as it related
17 to the treatment for withdrawal from benzodiazepines. Respondent was not familiar with the
18 common dosages, in addition to the correct spelling, of the prescribed medications.

19 20. Respondent failed to act as the patient's advocate by ensuring the intended
20 medication and dosage was being provided to the inmate. Respondent failed to transcribe a
21 medication order ensuring the correct medication and dosage. It is incumbent upon Respondent
22 to clarify the order with the prescribing physician or other responsible physician. Respondent
23 failed to clarify the order for which she was responsible, creating a delay in necessary treatment
24 intended to alleviate the symptoms of withdrawal from benzodiazepines.

25 21. Respondent was unfamiliar with the serving pharmacy's formulary vs. special order
26 available medications.

27 22. Respondent failed to demonstrate the correct method of indicating an error in
28 transcription.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

23. On or about October 12, 2007, Respondent was given eight orders to note by "Dr. L.," a staff psychiatrist at CIW. Dr. L. hand carried the orders to Respondent. Respondent advised Dr. L. that she was busy and unable to transcribe the orders until Monday. (October 12, 2007 was a Friday). Dr. L. requested Respondent endorse the orders to the oncoming nurse for transcription if Respondent really was incapable of completing it herself that day.

24. Respondent did not note the orders. The orders were found by another nurse on October 15, 2007. Dr. L. was surprised to discover the orders were not actually transcribed until Monday, October 15, 2007, when they were discovered by another nurse.

25. Respondent's failure to note the orders caused a three day delay in the patients' receiving their prescribed medications. The copies of the orders for the eight patients are very clear with regard to the time written and the delay noted by the other nurse.

26. When she was asked why she did not note the orders, Respondent denied speaking with Dr. L., and denied even knowing Dr. L., which is contrary to what Dr. L. stated.

27. A reasonable and prudent nurse who is invested in the welfare of her patients would have either noted and initiated the medication orders, or passed on to the relief shift the responsibility for transcribing the orders.

28. CIW nurses have access to the PYXIS machine so that medications can be pulled throughout the weekend in lieu of pharmacy staff providing them. There is no justification demonstrated for delaying the transcription of the orders.

29. Respondent's actions, particularly because eight patients were affected, constitutes gross negligence.

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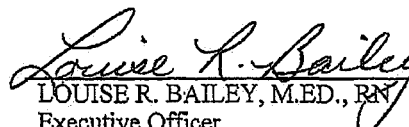
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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 591197, issued to Cynthia Hernandez;
2. Ordering Cynthia Hernandez to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
3. Taking such other and further action as deemed necessary and proper.

DATED: September 27, 2011


LOUISE R. BAILEY, M.E.D., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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Exhibit B

Letter of Public Reproval in Case No. 2012-178

Board of Registered Nursing
P O Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov
Louise R. Bailey, M.ED., RN, Executive Officer



February 6, 2013

Cynthia Hernandez
40393 Fabrizio Ct.
Indio, CA 92203

AND

78880 Sanita Drive
La Quinta, CA 92253

RE: LETTER OF PUBLIC REPROVAL
In the Matter of the Accusation Against:
Cynthia Hernandez, Registered Nurse License No. 591197

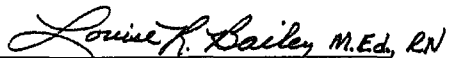
Dear Ms. Hernandez:

On September 27, 2011, the Board of Registered Nursing, Department of Consumer Affairs, State of California, filed an Accusation against your Registered Nurse License. The Accusation alleged that you engaged in unprofessional conduct under Business and Professions Code section 2761; and California Code of regulations, title 16, sections 1442 and 1443 regarding events which took place in 2007, wherein you were alleged to have made an error in writing a medication order for one patient on one date, and delaying notation of medication orders on another date.

Taking into consideration the documented personal and professional circumstances surrounding your employment at the time, including a negative work environment and the failure of supervisors to promote effective nursing care, and that there are other mitigating circumstances in this case that support the determination that you are safe to practice registered nursing, the Board has decided that the charges warrant a public reproof.

Accordingly, in resolution of this matter under the authority provided under Business and Professions Code section 495, the Board of Registered Nursing, Department of Consumer Affairs issues this letter of public reproof.

Sincerely,


LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California